

**STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES
DIVISION OF CHILD MENTAL HEALTH SERVICES**

DIRECTIONS FOR COMPLETING INITIAL APPOINTMENT APPLICATION

General Directions:

The initial application form is to be submitted by all licensed clinical staff who are defined under the Policy on Staff Accountability as requiring appointment to the DCMHS practitioner panel. The application form must be printed legibly or typed and all applicable sections fully completed and signed. Incomplete applications will result in failure to comply with division policy and where applicable division contracts.

A. Identifying Information

Name

This is the full legal name of the applicant requesting initial appointment and as listed on your professional license.

Date of Birth:

List the applicant's Month/Date/Year of birth. This is a required item necessary for conducting primary verification of education and licensure and for accessing the National Practitioners Data Bank.

Discipline:

Check (☒) the box which represents your appointment request.

B. Education Information*

Name and Address of Graduate College or University

This is the complete address of the graduate/medical school which awarded your highest degree upon which your professional license is based.

Year Graduated

This is the year in which you were awarded your highest degree.

***NOTE:** The applicant is responsible for arranging and ensuring that official letters or transcripts from graduate/medical schools which awarded your highest degree of professional training are sent directly from the source to the DCMHS Credentialing Committee at the address listed at the bottom of Page 5 of the application.

C. Additional Information If You Are Applying As A Psychiatrist:

Drug Enforcement Administration Number

This is the registration number listed on your Controlled Substance Registration Certificate issued by the United States Department of Justice allowing you to prescribe, dispense or administer controlled substances.

Date Registration Expires

This is the expiration date listed on the Federal Controlled Substance Registration Certificate.

ECFMG Number

This is the number issued by the Educational Commission for Foreign Medical Graduates for individuals graduating from a foreign medical school.

D. Practitioner Checklist

Check (✓) yes or no for each item as it applies to your professional clinical background. For each item checked yes, attach a detailed description of the event, including copies of relevant documentation. Supporting documentation must be sufficient for determining a clear understanding of the nature and outcome of the event.

E. Recommendation Form*

Two recommendations are required from professional peers who have knowledge of your competence to practice within the scope of your licensure. Individuals submitting recommendations must be licensed and in good standing with their respective regulatory board.

***NOTE:** The applicant is responsible for arranging and assuring that the recommendation forms are sent directly from the reviewer and received by the DCMHS Credentialing Committee at the address listed at the bottom of the recommendation form.

F. Practitioner Statement

This form is self-explanatory and must be returned, dated and signed by both the applicant and the Agency CEO or designee in management.

G. Credentialing Documents Checklist

Section I.

Delaware Professional License

Attach a copy of your current and valid Delaware Professional License.

Professional Resume

Attach a copy of your resume which provides evidence of continuous work history from the receipt of your baccalaureate degree and professional activities in delivering child, adolescent and family behavioral health services.

Current Malpractice Insurance Coverage

Attach a copy of your current professional liability insurance coverage. This does not apply to DCMHS employees.

Section II. Psychiatrists Only

Delaware Uniform Controlled Substance Registration Certificate

Attach a copy of your current and valid Delaware Uniform Controlled Substance Registration Certificate.

Federal Controlled Substance Registration Certificate

Attach a copy of your current and valid Federal Controlled Substance Registration Certificate.

Section III.

Detailed Description/Supporting Documentation

If applicable, attach additional paperwork addressing each item you checked “yes” to on the Practitioner Checklist.

Section IV.

Primary Verification and Recommendations

Indicate the name of your graduate/medical school and the date of your request to send transcripts to DCMHS.

Indicate the two names of your professional references and the dates you requested their recommendations.